

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000194	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2022
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NAME OF PROVIDER OR SUPPLIER WESTSIDE REHAB & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH COLUMBIA WEST FRANKFORT, IL 62896
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S 000	Initial Comments Annual Licensure and Certification Survey Done in conjunction with Event # 0W8J11: 2252266/ IL144932	S 000		
S9999	Final Observations Annual Licensure and Certification Survey Done in conjunction with Event # 0W8J11: 2252266/ IL144932 Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to prevent the verbal and physical abuse of a resident from another resident with a known history of abuse for 1 of 2 residents (R35) reviewed for abuse in the sample of 41. This failure resulted in psycho/social harm to R35 having feelings of fear, irritation, anger and feeling of being unsecure when R11 was at the facility.</p> <p>Findings Include:</p> <p>R11's Admission and Discharge Record documents R11 is a 76 year male resident with an admission date of 10/04/19 with diagnosis</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>including: Dementia with Lewy Bodies, Major Depressive Disorder, Anxiety Disorder and Bi-polar Disorder. R11's Minimal Data Set (MDS) dated, 12/31/21 documents R11's Brief Interview of Mental Status (BIMS) is documented as 09 (Moderately Impaired).</p> <p>R11's Behavior tracking dated 03/22 documents for the days between 03/01/22 and 03/17/22: Target Behavior: R11 will yell and cuss at peers 5 days a week, with a Goal listed as: R11 will yell and cuss at peers 2 days a week. R11's Behavior tracking documents: one shift of constant behaviors, 16 times that the behaviors occurred and 10 shifts with no documentation.</p> <p>R11's Care Plan dated 07/15/20 documents: Category: 7 Psychosocial: R11 has behaviors that others may find disruptive/socially inappropriate. Others may seek reprisal against this resident. Behavior exhibited history of verbal outburst. The goal dated 02/06/20 with new dates documented as: 01/27 (no year noted) and 03/28 (no year noted) states, Behavior of verbal outburst will have improved/deceased in the presence of others within the next 90 days. Category: 17 Psychotropic drugs: states, R11 requires use of Psychotropic medication to manage mood and/or behavior issues, with a goal date of 02/06/20 and revision dates of 01/27/21 and 03/28 (no year noted). R11's Intervention documented dated 11/08/19 states, refer to psychiatrist or neuro-psychologist for effective and safe behavior and medication management.</p> <p>R11's Nurse's Notes on 12/14/21 at 10:15 PM document: "I (V4, Licensed Practical Nurse) was putting window shades down when resident (R11) kicked me in the chest and said, "you ugly b**tch I will kick you again."</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>R11's Nurse's Notes on 12/15/21 at 12:30 PM document: "resident (R11) was seen walking across hall to engage a peer-resident. Was going to hit the peer when staff intervened."</p> <p>R11's Nurse's Notes on 12/15/21 at 3:45 PM document: "resident (R11) was seen standing in hall and starting to hit two peers as they passed R11 room- staff intervened,"</p> <p>R11's Nurse's Notes on 12/16/21 at 7:30 AM documents: "resident (R11) verbally assaulted peer and nurse and battered nurse while passing nurse in hall."</p> <p>R35s Admission and Discharge Record documents R35 is 58 year old male resident with an admission date of 05/04/2020 with diagnosis including: Cerebral Infarction, Vascular Dementia, Psychosis and Depressive Episodes. R35's Minimal Data Set (MDS) dated, 03/01/22 documents R35's Brief Interview of Mental Status (BIMS) is documented as 14 (Cognitively Intact).</p> <p>R11's Departmental Notes (Social Service Progress Notes) document on 03/14/22 at 8:20 AM ; Resident (R11) called another resident names. Then threw a cup of coffee in (R35) face. He (R11) then kicked him (R35) as staff separated them. There were no injuries noted by the nursing staff.</p> <p>R11's Departmental Notes (Social Service Progress Notes) on 03/14/22 at 10:35 AM documents: As a peer (R35) was propelling by in R35 wheelchair, a resident (R11) shook his (R11) fist and threatened to cut his(R35) penis off. Resident (R11) then tried to kick his peer (R35). Peer (R35) was not doing or saying anything to</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>him (R11). Staff separated wheelchairs and behavior ceased.</p> <p>R35's Departmental Notes (Nurse's Notes) dated 03/17/22 at 9:30 PM documents, "resident (R11) was standing in hall by the nurse's station waiting for nurse to pass by, nurse had staff stay by nurse to care for other residents, resident (R11) verbally threatened peer (R35) in dining room."</p> <p>On 03/31/22 at 2:05 PM, R35 stated R11 did kick R35, threw coffee at R35 face and told him, "he was going to cut off R35 penis" three times. R35 stated, R11's actions did upset R35, irritated R35 and made R35 angry. R35 stated, he would hope that R11 does not try to cut off his penis. The coffee was not hot so R35 was not injured but R35 did not like someone throwing coffee at R35 face, that made R35 angry also. R11 should not be able to do that to R35.</p> <p>On 04/05/22 at 2:45 PM, R35 stated he(R35) feels more comfortable and secure at the facility now that R11 no longer lives at the facility.</p> <p>On 03/30/22 at 11:40 AM, V14 (Social Service Assistant (SSA)) stated, R11 is the one that verbally threatened R35 in the dining room, R11 told R35 that, "He was going to cut his penis off" on 03/14/22 and 03/17/22. R11 also threw coffee in R35's face on 03/14/22. R11 does get verbally and physically aggressive. The staff will try to separate the residents quickly. There previously was a psychologist that came to the facility but they have not been in the facility since before Covid-19. V14 (SSA) stated, if physical or verbal aggression is witnessed between residents or with staff and a resident, it should always be reported to the Administrator, Director of Nursing, or charge nurse at the time.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>On 03/31/22 at 2:40 PM V25 (Regional Administrator) stated, there was no investigation done for the incidents that happened between R11 and R35 on 03/14/22 or 03/17/22. Residents and staff were not interviewed about the incident. Those incidents were not reported to IDPH or the police. V25 (Regional Administrator) stated, she is not aware of those incidents being reported to Administration. V25 (Regional Administrator) stated, the incident with the coffee and kicking should have been investigated and reported however, she is not sure about the verbal incident, she is not for sure if R35 heard him or was bothered by him. And, if someone have asked R35 about the incident to know if it bothered him. The facility's Abuse policy was not followed.</p> <p>The Facility policy dated 11/28/16 titled, "Abuse Prevention Program" documents: Policy: This facility affirms the right of out residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is t assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents.</p> <p>(B)</p>	S9999		